EXHIBIT 11

CONSENT FOR MENTAL HEALTH RECORDS SEARCH

This consent MUST be completed by the firearm applicant.
Failure to consent requires denial or disapproval of the application.

N.J.S.A. 30:4-24.3 provides that all records of any individual's commitment to a non-correctional institution for mental health reasons shall be confidential and shall not be disclosed except in limited circumstances or with the consent of the individual.

PART ONE (To be completed by the applicant)

Name: (Last, Maiden, First, MI)	Date of Birth: (Month, Day, Year)	Social Security #: *See Privacy Act Notice Below.
RACHLIN, AVI A	[redacted]	[redacted]

Address: (Number & Street)	(Municipality)	(County)	(State)
32 ADAMS PLACE	FREEHOLD TWP	Monmouth	NJ

List Prior Addresses for past 10 years: ☐ NOT APPLICABLE

ADDRESS 1: Dates Resided From: 02/24 - 2001 To: 2/8 - 2021

(Number & Street)	(Municipality)	(County)	(State)
- 32 adams place	- Freehold	- Monmouth	NJ

ADDRESS 2: Dates Resided From: - To: -

(Number & Street)	(Municipality)	(County)	(State)
-	-	-	-

I, **AVI A RACHLIN** *am aware of my rights under N.J.S.A. 30:4-24.3, and the Health Insurance Portability and Insurance Accountability Act (HIPAA), 45 C.F.R. 164-50, and consent to the disclosure of my mental health records, including disclosure of the fact that said records may have been expunged, to the Chief of Police and the Superintendent of State Police, or their designees, for the purpose of verifying my firearms permit application and my fitness to own a firearm under N.J.S.A. 2C:58-3.* ***I understand that copies of this authorization shall be considered sufficient authorization for the release of records or for the disclosure of the fact of expungement.***

FREEHOLD TOWNSHIP POLICE DEPARTMENT
Investigating Police Department

POLICE OFFICER S. FOLEY #262
Witness (Print Name)

x P.O. [signature] #262
Signature of Witness

x avi a rachlin
Signature of Applicant

02/08/2021
Date

* Applicant's Social Security Number is requested pursuant to N.J.S.A. 2C:58-3(e) and disclosure is voluntary. The number will be used to expedite the application. Without this number, the processing of the application may be delayed. This number is considered confidential.

PART TWO (To be completed by County Adjuster's Office, Mental Health Institution and/or Doctor)

	Record of Admission Commitment or Treatment	Date of Check	Signature of Authorized Official or Doctor (Dr.: Provide Medical License #)
County Adjuster's Office	☐ Yes ☐ No ☐ Expunged		
Institution or Doctor	☐ Yes ☐ No ☐ Expunged		

PART THREE (To be completed by authorized official or doctor only if applicant has record of admission, commitment, or treatment at a hospital, mental institution or sanitarium for a mental disorder)

NAME OF HOSPITAL, MENTAL INSTITUTION OR SANITARIUM	ADMISSION (mo/day/yr)	DISCHARGE (mo/day/yr)	SIGNATURE OF AUTHORIZED OFFICIAL OR DOCTOR
		to	
		to	

Additional forms may be obtained through the New Jersey State Police, Firearms Investigation Unit, P.O. Box 7068, West Trenton, NJ 08628-0068, or via the internet at www.njsp.org/info/forms.html.

S.P. 66 (Rev. 01/15)